Tips on Reviewing a Trauma Chart

General Tips:

- Start with an open mind - don't pre-judge the case
- Keep the BIG picture in mind - How was the flow of care for the patient? Were there delays in care? Were reasonable decisions made? For this purpose, it is not about how the patient did, it is about how well your team did
- This is not about extracting data for the trauma registry, it's about evaluation the care delivered to the patient
- Be systematic and know what you are looking for - assess the chart but don't read it like a book from start to finish
- Have a list of audit filters and possible complications to track in sight

Evaluating EMS Care

- Scene time - How long was it? Were there delays in transport? If multiple patients were involved, were the triage decisions appropriate?
- Transport - Were there delays in care? Were vital signs documented? Were procedures documented? Was a TTA called from the field?
- Was there adequate notification to the receiving facility?
- Was the care rendered appropriate?
- Is there documentation of reasons for outliers (prolonged scene time, lack of immobilization, lack of intubation if indicated, etc.)
- Is a trip sheet present? Is the documentation legible and complete?

Evaluating ED Care

- Was a TTA called, based on identified criteria? Was there a delay in calling the TTA? Was the appropriate level of TTA called?
- Are the response times documented and appropriate for the TTA?
- Were ATLS guidelines followed?
- Is a primary assessment documented? Is a secondary assessment documented?
- Are assessment findings, including temperature, GCS, pain level, etc. documented?
- Are reassessments completed as indicated based on the patient's condition and/or defined by policy?
- Is there documentation of appropriate response to changes in condition?
- Are treatments appropriate for the patient's condition?
- Is the method for c-spine clearance documented?
- Are all procedures documented?
- Are medication administrations and the effect documented?
- For patients being transferred -
    - Is the elapsed time between ED arrival and discharge to another acute care facility greater than 6 hours?
    - For patients with an initial systolic blood pressure <90 or GCS<9, does the elapsed time for decision to transfer from ED arrival and transfer to another acute care facility exceed 2 hours?
    - Is there a definitive airway established before transfer for patients with GCS<9?

- Is there documentation of reasons for outliers (delay to OR, delay in transfer, prolonged ED time, etc.)?
- If required, is consultation with another trauma facility or burn center documented?
- Is there adherence to facility defined standards/protocols/guidelines for care and medications i.e. anticoagulant reversal, antibiotics, tetanus, influenza, etc.?
- Are there misreads or missed injuries? If so, were they appropriately addressed?

Evaluating Inpatient Care

- Are there unplanned returns to the OR?
- Are there OR complications?
- Are VTE prophylaxis measures started by day 3 of arrival at the facility?
- Are there unplanned transfers to the ICU from the floor?
- Are appropriate consults obtained?
    - PT
    - OT
    - Speech
    - Rehab
    - Social Services
    - Nutritional Services
- Are there unplanned readmissions?
- Review physician notes and dictations. How do their initial impressions compare with the eventual outcome?
- What service managed the care of the patient? Was the managing service the appropriate service?
- Are follow up test/procedures performed as indicated to rule out deterioration?